● **MAJOR CONTRIBUTION**

Prevention and Counseling Psychology:

Revitalizing Commitments for the 21st Century

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This article advocates the need for a much stronger emphasis on and commitment to the science and practice of prevention in counseling psychology. Historical and recent developments in the profession are highlighted, as are the changing U.S. demographics and societal needs that mandate an enhanced prevention focus for the field. A prevention-based agenda of four fundamental goals for counseling psychology is articulated. The goals include eight training domains and objectives as well as skills needed to support a prevention agenda for counseling psychology. Barriers and adjustments needed to give renewed vitality toward prevention are discussed. Prevention resources and funding opportunities are presented.

The search for efficacious interventions to prevent psychological disturbance, physical ailments, and human distress has produced major initiatives and discoveries in the 20th century. The mental hygiene and vocational guidance movements early in the century, the discovery of polio vaccines at midcentury, and programs to prevent drug and alcohol use and social violence in more recent years represent major attempts to reduce emotional and physical distress through prevention. Although counseling psychology has aligned itself philosophically and historically with the prevention of human dysfunction, in practice, prevention has not enjoyed a very influential position within the profession, partly due to barriers that have hindered its development. Training programs, heavily regulated by psychological licensure and accreditation boards, emphasize individual remediation, crisis intervention, and psychological dysfunction as major components of training while giving much less attention to systemic preventive interventions and psychological well-being. Likewise, agencies and institutions that fund counseling services have favored models of individual rather than institutional change to address human problems (Roche & Sadoski, 1996). The 1990s health care

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revolution has provided ample evidence of funding priorities that focus on disease and distress rather than health and well-being (Holden & Black, 1999). Taken collectively, these professional and institutional forces have propelled counseling psychology toward a crisis intervention model of helping and further from a prevention emphasis. One very visible manifestation of the lack of prominence given to prevention is that during the 30-year history of *The Counseling Psychologist* (*TCP*), it has never published a major contribution with prevention as the major focus and clearly articulated in the title. A major goal of this thematic issue, therefore, is to correct a longstanding omission and give renewed attention and vitality to prevention science and practice in counseling psychology.

This goal will be accomplished through this lead article and the two follow-up articles, which build on previous work that has urged counseling psychology to forge new roles and collaborations, reframe training, and inaugurate new research agendas in the task of prevention (Brabeck, Walsh, Kenny, & Comilang, 1997). This major contribution extends recent recommendations that mental health professions organize their prevention activities within a comprehensive, context-sensitive conceptual framework (Bogenschneider, 1996; Lorion, 1989; Trickett & Birman, 1989).

The lead article reviews the history of prevention, with special attention to prevention within counseling psychology; prevention is defined, evolving from previous conceptualizations of prevention; the importance of prevention is discussed; a prevention-based agenda, articulating recommended goals for the profession, is presented; and resources and funding opportunities for prevention activity are given. The two articles that follow will apply prevention concepts discussed in this article to two major contemporary social and political issues: eating disorders and intimate partner violence.

HISTORY OF PREVENTION

Few would disagree that it is better to prevent a problem than to correct it. Prevention applies regardless of the problem domain, be it cardiovascular disease, school failure, depression, drug abuse, or automobile breakdown. In daily activities, many people regularly take preventive actions. They use seat belts, secure homes, eat nutritious meals, use smoke alarms, receive prenatal care, maintain vehicles, and manage stress. Prevention is not new. Schmolling, Youkeles, and Burger (1997) trace the history of prevention back to preliterate and ancient civilizations, with communities using prayers and rituals to ward off unexplainable disasters and catastrophes. Karadimas (1997) discusses the treatment and prevention of psychological problems by ancient Greek philosophers. In U.S. society, prevention has been part of com-

mon folk wisdom, as reflected in colloquialisms such as “An ounce of prevention is worth a pound of cure” and “An apple a day keeps the doctor away.” Spaulding and Balch (1983) give a history of prevention dating back to the late 19th century, and Mrazek and Haggerty (1994) detail the history of events related to the prevention of mental disorders in the United States.

The history of prevention during the early 20th century includes the mental hygiene, child guidance, and eugenics movements and federal legislation such as the establishment of the National Institute of Mental Health (NIMH) in 1946. In 1908, the first mental hygiene society was established to “prevent nervous and mental defects” (Reisman, 1976, as cited by Spaulding & Balch, 1983, p. 61). Child guidance clinics became popular in the 1920s and 1930s as a means to prevent adult pathology by focusing on childhood problem behaviors. The eugenics movement, begun in the latter part of the 19th century and influenced by social Darwinism, advocated the prohibition of procreation among individuals with various disorders and pathologies. By 1935, there were 27 states with laws for sterilization of the “biologically unfit” (Ruch, 1937, as cited by Spaulding & Balch, 1983, p. 65). Nancy Gallagher’s (1999) book, *Breeding Better Vermonters: The Eugenics Project in the Green Mountain State*, chronicles a frightening and painful history of the movement. Eugenics raises powerful ethical and political issues and, fortunately, is no longer discussed as a viable prevention strategy. One must wonder, however, if advances in biogenetics will once again bring greater prominence to social and biological engineering as prevention strategies and to the severe ethical dilemmas that will follow. Shortly after World War II, the U.S. Public Health Service established the Communicable Disease Center (CDC), and in the early 1990s, the U.S. Congress officially changed the agency’s title to the Centers for Disease Control and Prevention, while keeping the CDC initials (Satcher, 1996).

During the second half of the 20th century, prominent preventionists George Albee, Gerald Caplan, and Emory Cowen brought increased attention to prevention. Caplan’s classic volume *Principles of Preventive Psychiatry* was published in 1964. During President Kennedy’s administration, Congress passed the Community Mental Health Centers Act of 1963, with an implicit goal of providing prevention services to the community (Spaulding & Balch, 1983). Community mental health psychologists came together in 1965 at the Swampscott Conference, establishing the community psychology specialty to promote prevention and practice in community mental health (Elias, 1987). In the early 1970s, Cowen’s (1973) historic chapter in the *Annual Review of Psychology* highlighted primary prevention’s goals: “to forestall dysfunction by reducing the occurrence of disorder, and to promote psychological health and well-being” (pp. 432-433). The first Vermont conference on the Primary Prevention of Psychopathology was held in 1975, and

the first issue of the *Journal of Primary Prevention* was published in 1980. Among federal agencies, the Office of Substance Abuse Prevention was created in 1986, becoming the Center for Substance Abuse Prevention in 1992. The American Association of Applied and Preventive Psychology (AAAPP), along with its journal, *Applied and Preventive Psychology: Current Scientific Perspectives*, was inaugurated during the 1990s.

Recent developments in prevention caused Cowen (1996) to observe that "primary prevention has advanced significantly in the past decade" (p. 247). As American Psychological Association (APA) president, Martin Seligman designated prevention as the theme of the 1998 APA convention. Recently, an innovative, peer-reviewed electronic journal, *Prevention and Treatment*, was launched by APA, and AAAPP conducted its first online conference in June 2000. Commenting on the growth of prevention science during the past 20 years, the director of the NIMH, Steven Hyman, observes that psychologists can make enormous contributions to the nation's health through prevention research and practice in the 21st century (Hyman, 1999).

Counseling Psychology and Prevention

A history of the counseling profession in the United States is generally traced to the early 20th century (Baruth & Robinson, 1987). The social reformer Clifford Beers (1908) initiated the mental hygiene movement, publishing *A Mind That Found Itself*, which advocated improved treatment and the prevention of mental illness. In the same year, Frank Parsons founded the Vocational Guidance Bureau of Boston, and a year later, *Choosing a Vocation* was published posthumously (Parsons, 1909), giving birth to vocational guidance. Because others have detailed a history of the counseling profession (Conyne, 1987; Heppner, Casas, Carter, & Stone, 2000; Neukrug, 1999), it is not necessary to repeat it, except to emphasize that the profession's history is closely affiliated with many of the major social and political movements and events of the 20th century: urban industrialization, return of war veterans, Russian Sputnik space launch, increased numbers attending colleges and universities, the search for racial and gender equality, and the health care revolution. The profession has voiced strong commitments to underserved populations and those experiencing life transitions, often brought about by rapid social change (Sue, Bingham, Burke-Porché, & Vasquez, 1999).

Except for a few bright spots, visible prevention activity within counseling and counseling psychology has been lacking for a long time. More than 20 years ago, Krumboltz, Becker-Haven, and Burnett (1979) observed that prevention "occupies last place in the hearts of counseling psychologists" (p. 588). A few years later, Goodyear and Shaw (1984) stated that "primary prevention strategies continued to be underused" (p. 561). After a compre-

hensive review of the history of counseling, counseling psychology, and primary prevention, Conyne (1987) concluded that the profession is very ambivalent toward prevention. Others have similarly lamented the lack of preventive training and practice in counselor education and counseling psychology (Kiselica & Look, 1993; Kleist & White, 1997; Sprinthall, 1990).

Research studying the professional roles of counseling psychologists has revealed that prevention is tangential to the major activities of counseling psychologists. Fretz and Simon (1992) examined several survey studies on how counseling psychologists spend their professional time and concluded that "there is consistent evidence that far more time is being spent on remedial, therapeutic activities than on the preventive and developmental/educational activities that have long been identified as major themes in the profession" (p. 5). This reality runs counter to a report discussing the unique perspective of the professional practice of counseling psychology, emanating from the Georgia Conference on the Future of Counseling Psychology (Kagan et al., 1988). As might be expected from the profession's leaders, their perspective on the role of counseling psychologists includes focusing on "the health and strengths of a person, of being less concerned with the etiology of pathology and more concerned with adaptation in social systems" (Kagan et al., 1988, p. 349). However, a recent description of counseling psychology (APA, 1999) defines the specialty in part: "Counseling psychologists help people with physical, emotional, and mental disorders improve well-being, alleviate distress and maladjustment, and resolve crises. . . . Practitioners provide assessment, diagnosis, and treatment of psychopathology" (p. 589). Although the complete definition is very expansive, prevention is not directly stated as an area of expertise or study. The focus is definitely on remediation and corrective activities.

Despite the emphasis on remediation, in recent history, the profession has produced pockets of exemplary prevention activity through publications and research, college and university counseling center programs, and professional networks. In the 1980s, Goodyear and Shaw (1984) edited special issues on prevention in education and community settings in the *Personnel and Guidance Journal* (now called the *Journal of Counseling and Development*). Two major books on primary prevention, *Improving Counseling Through Primary Prevention* (Baker & Shaw, 1987) and *Primary Preventive Counseling: Empowering People and Systems* (Conyne, 1987), were also produced. These volumes present history, conceptual models, and applications of primary prevention in counseling and counseling psychology. The Baker and Shaw (1987) text gives greater attention to primary prevention in schools. In a later article, Conyne (1991) updated the gains in primary prevention and their implications for the counseling profession. He argued that primary prevention strategies and training need to be given major priority

within counseling because the efficacy of primary prevention programs has been demonstrated. Two texts of the 1990s, by Capuzzi and Gross (1996) and J. J. McWhirter, McWhirter, McWhirter, and McWhirter (1998), focus on prevention and intervention for at-risk youth. The third edition of the *Handbook of Counseling Psychology* (S. D. Brown & Lent, 2000) includes sections on preventive developmental interventions and advocacy across the lifespan, with chapters on prevention with youth and older adults, prevention in the workplace, and health promotion. Prominent in the meta-analysis of primary prevention programs for children and adolescents by Durlak and Wells (1997) was research originally reported in the *Elementary School Guidance and Counseling* (*ESGC*) journal (now combined with *The School Counselor* and called *The Professional School Counselor*), a major publication outlet for counselors. *ESGC* was the second most frequently cited journal in the analysis. Research teams from the counseling programs of the Universities of Cincinnati and Georgia have been investigating the use of groups for preventive purposes with children, adolescents, and adults (Conyne, Wilson, Horne, Dagley, & Kulic, 1999). The researchers argue for an increased emphasis on prevention group work training, research, and practice into the next century.

University and college counseling centers expanded their roles during the past 30 years to include prevention and outreach activities to the broader campus community (Stone & Archer, 1990). A major impetus for the expanded role was a conceptualization of counseling service delivery by Morrill, Oetting, and Hurst (1974). These authors described the targets (e.g., individuals, groups), purposes (e.g., remediation, prevention), and methods of interventions (e.g., direct, indirect). The three dimensions of the model were schematically represented by a cube to better understand and visualize the interactions of the three components. During the intervening years, the model has been modified but still includes prevention as one purpose of intervention (D. Brown, Pryzwansky, & Schulte, 1995; Cuyjet, 1996). The expanded role of university and college counseling centers resulted in a myriad of prevention offerings on campuses on topics such as stress management (Romano, 1983), wellness (DeStefano & Hanger, 1990), alcohol and drug use (Meilman & Fleming, 1990), shyness (Martin & Thomas, 2000), and HIV prevention (Sanderson, 1999).

Professional organization of prevention within counseling psychology has been through the Prevention and Public Interest Special Interest Group (SIG), formed in the early 1990s and recently becoming a Section of Division 17. The Prevention SIG has published an annual newsletter, sponsored APA convention symposia, and met annually at the APA convention as a means to facilitate scholarship, professional networking, and interest within the division (e.g., Romano & Waldo, 1998a).

WHAT IS PREVENTION?

Although seemingly straightforward, prevention has been interpreted differently by scholars and practitioners. Literally, *prevention* means to stop something from happening (e.g., preventing depression, teen pregnancy, school dropout, polio). The public generally conceptualizes prevention in this way. In professional circles, however, prevention has not enjoyed such a simplistic definition. Early on, Caplan (1964) brought clarity to the word by proposing the terms *primary*, *secondary*, and *tertiary prevention* to refer to prevention efforts that attempt to reduce the number of new incidences of a disorder, lower the rate of prevalence of a disorder by targeting those at risk or those at early stages of a disorder, or decrease debilitating effects of an existing disorder, respectively. Although this public health definition of prevention has been the most commonly cited, Baker and Shaw (1987) argue that secondary and tertiary prevention are not prevention but remediation. Others consider tertiary prevention to be treatment (Albee, 1982; Cowen, 1983). Lorion, Price, and Eaton (1989) argue that tertiary prevention efforts are prevention if they prevent reoccurrence or significant consequences of a disorder.

One difficulty in applying the triadic primary, secondary, and tertiary classification system, which was originally designed for physical disorders, is the ambiguous and complex etiology of psychological and social problems. Unlike many physical illnesses, in most psychological and educational domains, the etiology of a problem is unclear. What causes a middle school student to aggress against classmates? How does domestic abuse begin? What are the precursors of adolescent drug abuse? We do not have clear and consistent answers to these and other similar questions.

In practice, it is often difficult to differentiate between primary, secondary, and tertiary prevention. For example, school-based programs to prevent student use of alcohol will usually be delivered to all students in particular classes or grades. It is not practical in most situations to differentiate between students who are at greater or lesser risk for using alcohol. Therefore, the program is delivered to everyone. The same can be said for prevention interventions offered in the workplace. A stress management program could be classified as primary, secondary, or tertiary prevention depending on the employees involved: primary prevention for those experiencing little stress, secondary prevention for employees at risk for stress (such as those working in a particularly stressful section of the company), and tertiary prevention for those who already have a stress-related disorder (e.g., muscular pain).

Gordon (1987) proposed an alternative prevention intervention classification system: universal, selective, and indicated. This system is based on a risk-

benefit balance; that is, the risk of the disorder is weighed against the costs, benefits, and discomfort of the preventive intervention. Universal prevention measures are generally agreed upon to be desirable for everyone in the population (e.g., seat belt use, proper nutrition, and physical exercise). Selective prevention interventions are desirable only if an individual or subgroup is at risk for a disorder; that is, the benefits are greater than the costs or risks (e.g., flu shots for the elderly). Indicated prevention measures apply to those who are at high risk for future development of a disease or disorder but are asymptomatic at the time (e.g., early mammogram screenings for women with a family history of breast cancer). Like Caplan's (1964) earlier classification, Gordon's (1987) system was originally developed to classify prevention interventions for physical disorders. Applying them to psychological and social disorders can be problematic because the etiology of social and psychological disturbances and unhealthy lifestyle choices is not as clearly defined compared to many physical ailments.

In 1990, NIMH was mandated by the U.S. Congress to prepare a policy and research report on the prevention of mental disorders. The Institute of Medicine (IOM) was commissioned by NIMH to prepare the report. The IOM appointed an interdisciplinary committee of scholars for the study, which culminated in the publication of *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research* (Mrazek & Haggerty, 1994). The work of the committee has received much attention in the literature, but not without controversy. Much of the controversy centers around the committee's definition of prevention. It defined prevention interventions as only those that occur before the onset of a disorder. The IOM committee used Gordon's (1987) system to classify prevention interventions and excluded health promotion. Albee (1996) criticized the IOM report for using a disease-based model of prevention and for ignoring social and political change as viable prevention interventions, especially given the higher rates of physical and emotional problems among economically disadvantaged people. Cowen (1994, 1996) offered a similar critique, preferring a more proactive wellness enhancement strategy as a conceptual basis for prevention.

To be clear about the meaning of prevention used in this article, our definition of prevention includes what has been traditionally called primary, secondary, and tertiary prevention (i.e., prevention interventions designed to reduce the incidence, prevalence, and impact of problem behaviors). We also include personal well-being (e.g., health promotion) and social and political change initiatives to improve environments where people learn, live, and work. We conceptualize prevention interventions as those having one or more of the following five dimensions.

1. *Stops (prevents) a problem behavior from ever occurring*. This is the traditional meaning of primary prevention, which is more appropriate for

physical disease than psychological or social problems. In our view, restricting the meaning of prevention to only primary prevention is too narrow for the mental health professions given the complexities of etiology and solutions for most mental health and social problems.

2. *Delays the onset of a problem behavior.* Some prevention efforts, especially those designed for children and adolescents, hope to delay the onset of problem behaviors. Given the extent of risk behavior and experimentation engaged in by youth, it is unrealistic to expect prevention programs to completely eliminate these behaviors. For example, among high school students, 60% have smoked cigarettes, more than 75% have consumed alcohol, more than 33% have used marijuana, and more than 66% have had sexual intercourse by their senior year of high school (Ozer, Brindis, Millstein, Knopf, & Irwin, 1998). In the case of tobacco addiction, the longer an adolescent avoids the use of tobacco, the less likely that he or she will become addicted to it.

3. *Reduces the impact of an existing problem behavior.* In traditional terms, this would be classified as tertiary prevention. However, again, the definition differs depending on the perspective. In recent years, cigarette smoking has increased among college students (Wechsler, Rigotti, Gledhill-Hoyt, & Lee, 1998). Therefore, a reasonable activity for college counseling and health centers is to implement smoking cessation programs. One might call this *tertiary* or *remedial prevention*, as the programs are designed to reduce the impact or stop the addiction. However, because one program goal is to prevent cardiovascular and lung diseases in later life, the programs are also primary prevention.

4. *Strengthens knowledge, attitudes, and behaviors that promote emotional and physical well-being*. Programs that teach life skills to youth (Botvin, 1995; Danish, 1997; Prothrow-Stith, 1994), stress management to adults (Kagan, Kagan [Klein], & Watson, 1995), and wellness strategies (Watt, Verman, & Flynn, 1998) are examples of health promotion interventions. These programs and strategies are designed to inoculate against harmful and potentially destructive behaviors of lifestyle.

5. *Supports institutional, community, and government policies that promote physical and emotional well-being*. These are systemic interventions to change environments where people live, work, and learn to prevent problem behaviors. The emphasis is on institutional rather than individual change. L. S. Hansen's (1997) Integrative Life Planning (ILP) model for career development incorporates a strong emphasis on systemic change with career development professionals serving as institutional change agents. Other examples include the prohibition of alcohol advertising in neighborhoods and health promotion policies in schools and employment settings (e.g., cafeteria food choices, smoke-free buildings).

Although Dimensions 1, 2, and 3 can be conceptualized in traditional primary, secondary, and tertiary terms, Dimensions 4 and 5 are conceptualized within a "risk-reduction" framework. Risk-reduction strategies (RRS) attempt to reduce characteristics, variables, or hazards that increase a person's vulnerability to a disorder or to strengthen factors that are protective against the disorder (Mrazek & Haggerty, 1994). RRS can be employed at the individual, group, or system levels and can address biological, psychological, social, and environmental variables. A needle-exchange program for intravenous drug users, for example, is an RRS for HIV and/or AIDS prevention, as is condom availability in high schools and colleges. On a group level, airport passenger screening and metal detectors are RRS that have greatly reduced incidents of hijackings and other violent airplane crime. Another example of RRS is the successful Head Start Program to promote early school achievement (Ripple, Gilliam, Chanana, & Zigler, 1999).

We believe that a broad conceptualization of prevention is needed. In much human distress, problem behaviors recycle themselves throughout the lifespan. Unfortunately, we cannot inoculate against human distress and unhealthy behaviors as we do so effectively for many physical diseases. We do not have a vaccine to inoculate against stress or one to prevent the use of tobacco. Although preventive technologies that require minimal or passive actions are effective (e.g., smoke alarms, automobile airbags), prevention is more difficult when active participation is required (e.g., changing smoke alarm batteries, adhering to traffic laws). Prevention interventions designed to prevent complex psychological dysfunctions and addictions are even more problematic, because causal relationships are not always clear and are influenced by contextual factors. Therefore, although it is preferable to prevent a disorder or problem behavior from ever occurring, in many situations, this narrow goal is unrealistic.

It is equally important that prevention be conceptualized from wellness, well-being, health promotion, and resiliency perspectives. These terms, used by various authors (Haggerty, Sherrod, Garmezy, & Rutter, 1994; Lightsey, 1996; Romano, Miller, & Nordness, 1996; Simeonsson, 1994), focus on building skills and assets that promote positive human development. The goal is to reduce the potential for distress by strengthening abilities to withstand risks.

WHY IS PREVENTION IMPORTANT?

There is a growing societal momentum that supports making prevention more integral to counseling psychology. *Healthy People 2010* (U.S. Department of Health and Human Services [USDHHS], 2000) is the latest edition of

a national public health agenda that was inaugurated in 1979 and revisited in 1990. *Healthy People 2010* is a 10-year plan of national objectives to improve health and prevent disability, disease, and premature death in the United States. The two broad goals of *Healthy People 2010* are to increase the quality and years of healthy life and to eliminate health disparities based on ethnicity, social class, and education. These goals are critically important for a U.S. population that is becoming increasingly older and more diverse. The document addresses 10 targeted health indicators to improve the overall health and well-being of U.S. citizens. They include mental health, injury and violence, physical activity, overweightness and obesity, tobacco use, substance abuse, and responsible sexual behavior. All of these areas are integrally related to behaviors of lifestyle and choice and thus offer major prevention opportunities for psychologists. In the preface to *Healthy People 2010*, Donna Shalala, U.S. Secretary of Health and Human Services, challenges clinicians to include prevention in their practice, scientists to expand research agendas, and leaders to support health-promoting policies in schools, workplaces, and communities to meet the 10-year health objectives.

Prevention is critically important because of low remedial service use rates and options in the United States. Based on the *Consumer Reports* readership study ("Mental Health," 1995), VandenBos (1996) estimated an 18.6% psychological services use rate during a 3-year period and a lifetime use rate of 26%. Depression is the most common mental health problem in the United States and the leading cause of disability, but only 23% of adults diagnosed with depression received treatment in 1997 (USDHHS, 2000). Contributing to low psychological service use rates is the lack of health care insurance coverage. Forty-four million adults lack health insurance, and one third of the Hispanic population in the United States had no health insurance in 1997 (USDHHS, 2000). Adolescents have the lowest use of health care services of any age group and are less likely to have health insurance (Ozer et al., 1998). Hoagwood and Koretz (1996) estimate that 60% to 80% of children in need of mental health treatment do not receive such help.

In addition to low use rates, several social and psychological health indicators argue for the importance of prevention. From 1970 to 1993, Miringoff (1995) cites significant increases in the number of children living in poverty, child abuse, teen suicides, adolescent pregnancies, and unemployment. In 1991 alone, approximately 130,000 youth aged 10 to 17 were arrested for rape, robbery, homicide, or aggravated assault, representing an increase of 48% since 1986 (Lerner, 1995). Others have identified a myriad of social problems that place youth "at risk" (J. J. McWhirter et al., 1998), creating a growing sense of urgency about the necessity to address the needs of children, youth, and families (Brindis, 1993; Durlak, 1995).

Lifestyle and addictive behaviors (e.g., lack of physical exercise, tobacco use) that begin early in life lead to major, costly health problems in adults (Kolbe, Collins, & Cortese, 1997). For example, 40% of adults engage in no leisure-time physical activity, and cigarette smoking continues to be the single most preventable cause of death and disease, resulting in more deaths each year than AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires combined (USDHHS, 2000). During the period from 1990 to 1997, the percentage of all adolescents smoking cigarettes increased to 36%, whereas adult smoking remained stable at about 24% during the same period (USDHHS, 2000). Data on adolescent smoking behavior support the need for differentiated prevention programs. For example, among White high school students, 40% smoked, compared to 34% of Hispanic students and 23% of African American students. Only 17% of African American high school girls smoked in 1997 (USDHHS, 2000). The cost to society of largely preventable problems includes drug abuse ($110 billion), alcohol abuse ($167 billion), and mental illness ($150 billion) (USDHHS, 2000).

Another related change that supports prevention is an increasing disillusionment with a medical or disease model of care with emphasis on repair of pathology, individual intervention, psychotropic drugs, and insurance reimbursements (Albee, 2000; Duncan, 1994; Holden & Black, 1999; Myers, 1992). As noted by Cowen and Work (1988), such a focus is often costly, time consuming, culture bound, and unavailable to people from lower income groups, including children and older people. Seligman and Csikszentmihalyi (2000), reflecting on psychology's almost exclusive focus on pathology and personal dysfunction, argue for a much stronger emphasis on "positive psychology" to facilitate the growth and development of individuals, groups, and societies.

Parallel to an awareness of the limitations of the medical model is an interest in "wellness" (e.g., healthy diet, physical exercise, stress reduction, and career-family-leisure balance) and the use of alternative or complementary medical practices. One national study found that 46% of the sample visited an alternative medical practitioner during 1997, compared to 36% in 1990 (Eisenberg et al., 1998). Although the focus has largely been on physical rather than mental health (Groves, Leeson, & Sovine, 1989), complementary medical practices have increased the awareness of the interdependence of physical and mental health.

A final change taking place is newer conceptualizations of psychological practice that emphasize multiculturalism (Sue, Arredondo, & McDavis, 1992; Sue, Ivey, & Pedersen, 1996), systemic interventions (Cottone, 1992; L. S. Hansen, 1997; McAuliffe & Eriksen, 1999), and interdisciplinary collaborations (Lerner & Simon, 1998). Effective service is viewed as context specific, culturally relevant, and grounded in the family and the larger com-

munity (Bronfenbrenner, 1986; Gager & Elias, 1997; Kulstad-Swartz & Martin, 1999). Citizen participation and empowerment, social action, and environmental change strategies are seen as integral to psychological practice (Lewis, Lewis, Daniels, & D'Andrea, 1998) and to health enhancement (Duncan, 1994). It is becoming increasingly apparent that the health of the individual is related to the health of the community (Hoffman & Driscoll, 2000).

A PREVENTION-BASED AGENDA FOR COUNSELING PSYCHOLOGY

To give renewed centrality and prominence to prevention in counseling psychology, we propose a prevention-based agenda for the profession that promotes four major goals: (a) greater use of systemic and integrative theoretical models and approaches; (b) increased emphasis on early preventive interventions with children and youth; (c) prevention interventions that are sensitive to racial, ethnic, and other forms of diversity; and (d) training domains, objectives, and skills that support the science and practice of prevention.

Goal 1: Use of Systemic and Integrative Models

Several theoretical perspectives support this goal, including Bronfenbrenner's (1979, 1986) ecological approach, developmental contextualism (Lerner, 1991, 1995), and models emphasizing protective processes and resiliency (Garmezy, 1993; Werner & Smith, 1992). Each of these perspectives offers insights that can guide prevention efforts. The search for one all-encompassing approach that has the potential to propel a paradigm shift toward a greater prevention focus in counseling psychology is not realistic. As suggested by Bogenschneider (1996) and others (e.g., Winett, 1998), a thoughtful integration of different approaches appears to offer the best option for developing an agenda for effective prevention interventions, research, and public policy.

This goal focuses not only on one but on many aspects of the human ecology to form multifaceted and comprehensive interventions (Bronfenbrenner, 1979; Dumas, 1989; Weissberg & Elias, 1993). For example, in addressing a concern such as teen pregnancy, one needs to consider the immediate setting (e.g., interactions in the school and home), organizational structures (e.g., the physical and social environments of these settings), the interaction of one setting (e.g., parental norms) with another (e.g., peer influences), and institutional policies (e.g., government and community regulations and norms). Changes in one setting will affect other settings, creating a change in the entire system.

This goal also fosters competencies in negotiating social systems, building on existing personal and community strengths that can function as protective processes, for example, a life skills development focus that includes training to enhance communication, problem solving, and motivation (Lewis et al., 1998). Danish's (1997) award-winning "Going for the Goal" is one prominent program teaching life skills to youth. A significant body of research supports development of resiliency in children and adolescents (e.g., Cowen & Work, 1988; Masten, Best, & Garmezy, 1990) and positive youth development (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 1999; Larson, 2000).

Goal 2: Early Interventions With Children and Youth

A second goal is for early preventive interventions with children and youth to be fully embraced by the profession. Programs should begin early (e.g., school-based prevention curricula) by targeting children and youth, especially those at high risk for developing emotional problems (Coie et al., 1993; Cowen, Hightower, Pedro-Carroll, & Work, 1996; Winett, 1998). Early intervention research has expanded, as reflected in several research reviews (Durlak, 1995; Durlak & Wells, 1997). To fully embrace early interventions with youth, counseling psychology needs to rid itself of fear of the schools or "school phobia," as named by Brabeck et al. (1997), and enter into active collaboration with school personnel, parents, and administrators. Multiple collaborators in the prevention of problems such as school dropout (Franklin & Streeter, 1995) and school violence (Orpinas et al., 1996) are needed.

Goal 3: Racial, Ethnic, and Diversity Issues in Prevention

A third goal is for prevention interventions, training, and research to be sensitive to racial, ethnic, and other forms of diversity to strengthen healthy development at the individual, group, and community levels (Botvin, Schinke, & Orlandi, 1995; Cázares, 1994). Interventions must respect cultural norms and beliefs of the population and setting served. Preventionists must be aware of historical, social, and political factors that contribute to institutional racism, poverty, and oppression, which in turn place particular groups as well as entire communities at risk for physical and emotional distress (Thompson & Nelville, 1999). Failure to consider these factors will limit the effectiveness of prevention interventions (Delva-Tauili'ili, 1995; Goddard, 1993). The proactive use of multicultural competencies (Arredondo, 1999) in the name of prevention to enhance physical and emotional health is advocated. Multicultural competency is particularly critical given changing

U.S. demographics, with major increases in the percentage of racial and ethnic minority students in the public schools and employees in the workplace (Sue et al., 1999).

The target group needs to be involved in program design, planning, and implementation of prevention efforts at the earliest stages (Bogenschneider, 1996; Schinke, 1994). Words from Lila Watson, an aboriginal woman, illustrate the mutual growth-enhancing connections needed between prevention practitioners and researchers and resident communities: "If you have come to help me you can go home again. But if you see my struggle as part of your own survival then perhaps we can work together" (Montgomery-Fate, 1997, p. 6). What is needed is a relationship in which both partners listen intently and dialogue about their concerns in order to join together in a common effort to create positive change. An exemplary model of AIDS education and prevention within the African American community, using Africentric frameworks of NTU (loosely translated as "essence of life") and Nguzo Saba, is one example of a culturally relevant prevention program. The principles of NTU include harmony, interconnectedness, authenticity, and balance. The principles of Nguzo Saba are unity, self-determination, collective work and responsibility, cooperative economics, purpose, creativity, and faith (Foster, Phillips, Belgrave, Randolph, & Braithwaite, 1993).

Goal 4: Training Domains, Objectives, and Skills

A renewed prevention agenda for counseling psychology requires a training emphasis that gives students necessary knowledge and skills to effectively engage in the science and practice of prevention. The training domains, objectives, and skills that we recommend to support a prevention agenda for the profession are discussed below and summarized in the appendix.

Domain 1: Community and multidisciplinary collaboration. Effective prevention requires the ability to form effective partnerships, and students need skills in developing community and multidisciplinary collaborations. They also need greater exposure to theories, research, professional roles, and ethical codes of other disciplines such as education, law, nursing, public health, and social work (Brabeck et al., 1997). Preventing many psychological and social ills in the 21st century will demand the creative talents of multidisciplinary teams of professionals. Greater understanding across disciplines will enhance prevention theory, interventions, and research. One example of the use of multidisciplinary and community partnerships was presented in a series of articles describing and evaluating CDC-sponsored violence prevention projects (Powell et al., 1996).

Domain 2: Social and political history. Students must become knowledgeable about the histories related to the major social problems of the day, including racism, poverty, discrimination, alcoholism, drug abuse, and social violence. Knowledge about the etiology of these problems and how they contribute to mental, emotional, and physical disorders will better prepare counseling psychologists to combat social conditions that foster human dysfunction from a preventive and systemic perspective.

Domain 3: Protective factors and risk-reduction strategies. Prevention science has given much attention to conditions and behaviors that either protect or put a person at risk for physical and psychological problems. It is important that the social, cultural, and institutional conditions as well as personal behaviors that place people and groups at risk are understood by psychologists. Equally important is an understanding of conditions and personal characteristics that offer physical and emotional health protection. Counseling psychologists need to understand how protective factors influence the development of health and well-being and how risk factors lead to distress and dysfunction. The study of resiliency, especially in children and adolescents, is one area of investigation examining the influence of protective factors (Haggerty et al., 1994; Luthar & Zigler, 1991), and another example is from MacCoun (1998), who employed a harm reduction framework for drug prevention.

Domain 4: Systemic intervention. Counseling psychologists need to give greater attention to institutions where people live and work and recognize the connectedness between societal institutions (Sowers, Garcia, & Seitz, 1996). These institutions include employment settings, schools, religious or spiritual organizations, and neighborhoods. Development of skills to design and implement interventions to change institutional norms and policies for the enhanced health and well-being of people are needed. Specific skills include the ability to work effectively with large organizations and communities, applying group leadership skills, and specifically attending to group process dimensions. Examples include interventions to improve corporate management practices to reduce stress, school procedures to increase cooperation rather than competitiveness among students and staff alike, and community mobilization to prevent alcohol and drug use among youth. An example of the latter is "Project Northland," a multilevel, community-wide research program for alcohol prevention (Perry et al., 1996).

Domain 5: Political and social environment. Understanding the social context in which prevention activities are planned and carried out is critical for successful prevention (Elias, 1987). Counseling psychologists must

become familiar with patterns of behavior, sources of power, norms, and political realities in the environments in which they operate as preventionists. As in individual work, failure to confront the problems of the social system limits the effectiveness of the specific intervention (Antonovsky, 1994). Similar to Domain 4, skills in group leadership and advocacy are necessary.

Domain 6: Psychoeducational groups for prevention. Developing, delivering, and evaluating workshops, classes, school-based curricula, and other types of psychoeducational groups are common activities for counseling psychologists, and they are often conceptualized as prevention. However, specific training to develop, implement, and assess outcomes of psychoeducational groups is missing from many counseling psychology training programs. Students need more deliberate training on the use of psychoeducational groups to support a prevention agenda. A special issue on psychoeducational groups in the *Journal for Specialists in Group Work* ("Psychoeducational Group Work," 2000) gives examples of innovative psychoeducational groups.

Domain 7: Prevention research and evaluation. Prevention research and evaluation studies need to incorporate practitioners and researchers from multiple disciplines and examine an array of questions across the lifespan, including policy-relevant concerns (W. B. Hansen, Miller, & Leukefeld, 1995; Koretz & Moscicki, 1997). Counseling psychologists need to develop skills in conducting needs assessments and program evaluations to complement more traditional research expertise. Prevention research includes epidemiological, longitudinal, and experimental studies using both quantitative and qualitative methodologies. Research and evaluation studies need to be multifaceted and measure changes in systems and institutions as well as individuals. In designing evaluation and research studies, attention must be given to contextual variables, such as race and/or ethnicity, socioeconomic backgrounds, and community and family norms (Dumas, 1989; Mitchell, 1997).

Recent NIMH (1998) recommendations for prevention research identify several initiatives that are particularly relevant for the scientist-practitioner counseling psychologist. These research recommendations include studies of early childhood risks for adverse developmental outcomes, the prevention of depression and anxiety across the lifespan, expanding the scope of prevention research to include a broader array of disorders and social units (e.g., schools, families, communities), expanding studies on comorbidity prevention (i.e., risk and protective factors of co-occurring illnesses), long-term follow-up in prevention research, and developing the capacity to train prevention researchers.

Counseling psychology can effectively promote research and evaluation studies given the specialty's strong commitment to both science and practice.

However, counseling psychologist training needs to broaden student exposure to include participation on multidisciplinary and collaborative research-evaluation teams, in research and evaluation studies that address systemic and institutional change, and with projects that examine contextual factors and that effectively disseminate research and evaluation findings to relevant audiences and policy makers. One example currently underway is a *Wallace Reader's Digest*–funded initiative to transform the role of the school counselor. The first stage of this initiative focuses on innovative school counselor training in six demonstration projects throughout the United States (*National Program*, 1999). Counseling psychology faculty and students are involved in this systemic and interdisciplinary initiative.

Domain 8: Prevention ethics. Prevention ethics needs to be included in the training of preventionists. Although some of the issues are similar to traditional ethical standards (e.g., confidentiality, informed consent), others also need to be considered. Pope (1990) has addressed conceptual and procedural issues for ethical accountability in prevention, including social equity and justice. Clarke (1993) has discussed the importance of fidelity to the prevention protocol and minimizing attrition during long-term follow-up. The importance of addressing prevention ethics in training programs has been examined by Bond and Albee (1990). Their review of prevention courses showed that ethics was not addressed in most courses. As students become engaged in cross-disciplinary collaborations, familiarity with ethical issues and dilemmas beyond psychology is required (NIMH, 1993).

Barriers and Opportunities

A prevention-based agenda in counseling psychology will require adjustments in professional perspectives, training program curricula, and practica and internship expectations. However, change will not come easy. Reviewers of earlier drafts of this article raised very legitimate questions about obstacles that may prevent counseling psychology from adapting a renewed emphasis on prevention science and practice, especially given the realities of remedial service delivery demands, accreditation and licensing board requirements, employment opportunities, and the difficulties associated with curriculum change in higher education. Although the questions are valid, the changing demographics of the U.S. population, the escalating cost of health care, and the complex relationships between the social, emotional, and physical dimensions of the human condition are exceptionally strong reasons for implementing a prevention-focused agenda in counseling psychology. In our opinion, these reasons far outweigh the status quo that emphasizes a remedial, crisis mentality model of care. Others share similar opinions (Holden & Black,

1999; Schmolling et al., 1997; Seligman & Csikszentmihalyi, 2000). More practically, institutions that employ counseling psychologists, including higher education, will seek professionals who can work within a collaborative, multidisciplinary framework. Policy makers and funding agencies, recognizing the importance of partnerships and cross-disciplinary collaborations, are setting national priorities to optimize best practices in prevention science through collaborative relationships (Brindis et al., 1997; NIMH, 1993; Ramey, 1999).

A recent APA convention symposium (Romano & Waldo, 1998b) highlighted several APA-accredited counseling psychology programs that have made prevention a priority: Boston College (Walsh, Kenny, & Brabeck, 1998), New Mexico State University (Vázquez, Kaczmarek, & Waldo, 1998), and the University of Oregon (B. T. McWhirter, McWhirter, Hunt, & O'Leary, 1998). Adaptations that these programs have made to give greater attention to prevention include the following: (a) developing practicum settings that give students greater opportunities to apply and evaluate prevention interventions, (b) providing opportunities for faculty and students to engage in prevention-based multidisciplinary and intercollegiate curriculum and research initiatives, (c) emphasizing theoretical models of change that consider the multifaceted systemic environment of clients and institutions, (d) teaching prevention and evaluation research methods, (e) addressing multiculturalism and social action as critical components of counseling curricula, and (f) offering a balanced perspective of the theory and practice of counseling by assessing and promoting client strengths and resiliency rather than emphasizing client deficits, as presented by traditional models of counseling and psychotherapy.

PREVENTION RESOURCES AND FUNDING OPPORTUNITIES

Resources for prevention practices, training, and research are available from local, state, and national organizations. The United States government agencies provide the largest volume of information and funding opportunities for prevention work. In addition, federal dollars are offered in block grants to state agencies to support local prevention projects. The Internet provides access to numerous prevention resources and grant proposal requests. Listing all of the available resources is beyond the scope of this article; however, several major resources are provided as examples that readers may investigate.

- An Ounce of Prevention: Prevention Yellow Pages (http://www.tyc.state.tx.us/prevention) is a worldwide directory of programs, research, and resources for youth (Texas Youth Commission Office of Prevention, 4900 North Lamar Boulevard, Austin, TX 78765-4260).

- APA's Federal Funding Bulletin (http://www.apa.org/science/bulletin.html) provides federal grant information of interest to psychologists.
- APA Public Interest Directorate Healthy Adolescents Project (http://www.apa.org; 750 First St. N.E., Washington, DC 20002-4242).
- American Association of Applied and Preventive Psychology (http://w3fp.arizona.edu/aaapp) promotes clinical and preventive psychology (P.O. Box 3822, Tucson, AZ 85722).
- National Institutes of Health (http://www.nih.gov), under the U.S. Department of Health and Human Services, administers 25 institutes and centers, including those on cancer, aging, alcohol abuse, child and human development, drug abuse, mental health, and nursing. NIMH administers an Office of Prevention (http://www.nih.gov/grants/ grantinfo2.chm).
- Substance Abuse and Mental Health Services Administration (SAMHSA) administers the National Clearinghouse for Alcohol and Drug Information (NCADI), the Center for Substance Abuse Prevention (CSAP), and PREVLINE. PREVLINE (http://www.health.org) is a comprehensive collection of prevention programs, resources, statistics, and government and private funding opportunities. CSAP administers six regional centers throughout the United States for the Application of Prevention Technologies (CAPT). The centers offer resources and technical assistance for alcohol, drug, and violence prevention (http://www.captus.org).
- Department of Justice grant programs can be found at http://www.ojp.usdoj.gov. The U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP) (http://www.ojjdp.ncjrs.org) focuses on the prevention and control of juvenile crime.
- U.S. Department of Education (http://www.ed.gov) and, specifically, the Office of Elementary and Secondary Education (OESE) (http://www.ed.gov/offices/OESE) and the Safe and Drug Free Schools Program (http://www.ed.gov/offices/OESE/SDFS) provide a range of resources and school-based funding opportunities.
- CDC (http://www.cdc.gov) provides funding opportunities, statistics, and information. The CDC Prevention Guidelines Data Base includes more than 400 documents for the prevention and control of public health threats such as AIDS, sexually transmitted diseases (STDs), and suicide. The CDC's National Prevention Information Network (NPIN) focuses on HIV/AIDS, STDs, and tuberculosis.
- Behavioral and Social Science Volunteer Program (BSSV), funded by the CDC through APA, is a network of behavioral and social science volunteers who assist communities with HIV prevention efforts (http://www.apa.org/pi/aids/bssv.html).

Examples of other sources of information and funding include the following: National Science Foundation (http://www.nsf.gov), U.S. Department of Housing and Urban Development (http://www.hud.gov), Center for AIDS Prevention Studies (http://www.caps.ucsf.edu), and Center for the Study and

Prevention of Violence (http://www.colorado.edu/cspv). A resource for private foundation grants is The Foundation Center (http://www.foundationcenter.org). In addition, there are local sources of support through community foundations, municipalities, school districts, and universities.

As the above examples demonstrate, there is an abundance of information and several major funding sources to support prevention projects and research. However, this information will only be relevant to counseling psychology to the extent that the profession reframes its programmatic and research agendas to include a commitment to prevention as a significant and major emphasis of the field. As suggested in this article, one initial step is to reduce the profession's emphasis on the medical model of individual remedial care, which Seligman (1998) states has left psychology "ill equipped" to work in the prevention arena. We also need to increase our collaborations with other psychological specialties, community agencies, and professional disciplines to bring expertise and influence to the prevention of social problems. Through increased collaborations and a renewed vision, counseling psychology can become a major force in the prevention of human problems.

ARTICLES TO FOLLOW

This thematic contribution hopes to bring prevention into a more central role within counseling psychology. Opportunities and collaborations for counseling psychologists have been suggested. A prevention-based agenda has been outlined and research areas presented.

Each of the articles that follow will address an important contemporary issue and its relationship to counseling psychology in light of this newly envisioned focus on prevention. The articles represent illustrations of prevention initiatives and opportunities for preventive interventions. Obviously, there are a number of possibilities for counseling psychologists to intervene in systems and organizations to reduce the incidence of problematic behavior. Although these articles offer examples with particular populations and environments, they may stimulate others to apply prevention concepts and frameworks to other populations and settings.

The first article, by Mussell, Binford, and Fulkerson (2000 [this issue]), discusses the prevention of eating disorders, a societal problem that causes much emotional and physical distress for individuals, families, and communities. The authors examine risk factors associated with eating disorders, including racial and/or ethnic differences for groups at risk for developing eating disorders. Initiatives for the prevention of eating disorders and research outcomes in educational settings, from grade school through college, are presented.

Opportunities for counseling psychologists are discussed, with attention to the prevention agenda and training of counseling psychologists set forth in this article.

The second article, by Hage (2000 [this issue]), addresses a major societal problem that urgently needs the attention of preventionists (i.e., male violence against female intimates). In addition to background and definition considerations, Hage attends to critical social and cultural issues influencing intimate partner violence. She offers descriptions and examples of prevention interventions that correspond to the preferred prevention definition articulated in this article, including social and institutional policy initiatives to prevent intimate partner violence. Opportunities for counseling psychologists to collaborate with community agencies (e.g., schools, legal and health services, faith communities) are presented.

Although each article is different given the unique perspectives of the authors and the different topics presented, the two articles follow a common broad structure that includes background, theoretical themes associated with a prevention agenda, model prevention programs, and significant issues for counseling psychology, such as research and/or evaluation, training, and employment. Our hope is that this major contribution will help create a shared vision aimed at addressing the enormous needs of today's children, youth, families, and communities and will revitalize the commitments of counseling psychology toward an enhanced prevention focus in the 21st century.

APPENDIX
Training Domains, Objectives, and Skills

Domain 1: Community and multidisciplinary collaboration

Objectives:

- To learn roles and needs of community agencies;
- to understand the philosophical foundations, knowledge bases, and common practices of disciplines and specialties outside of counseling psychology; and
- to develop group leadership skills to facilitate group cohesion, productivity, and teamwork.

Domain 2: Social and political history

Objectives:

- To learn the history and etiology of social problems;
- to become knowledgeable about the relationship between contemporary problems and their political and social histories;
- to learn how groups have been disempowered through racism and social and political discriminatory practices; and

- to develop an awareness of the social and political realities that place individuals and groups at risk for psychological dysfunction.

Domain 3: Protective and risk factors
Objectives:
- To learn the relationship of protective and risk factors for individuals and groups;
- to develop skills to implement risk-reduction strategies; and
- to develop skills to promote protective factors for individuals and groups.

Domain 4: Systemic intervention
Objectives:
- To learn models of system theory and frameworks for interventions;
- to learn how the social dynamics of institutions and organizations affect individuals;
- to develop system intervention skills to promote institutional change; and
- to use group leadership skills, including group process and group dynamic dimensions.

Domain 5: Political and social environments
Objectives:
- To develop an appreciation for political and social contextual factors that affect institutional settings, communities, and neighborhoods;
- to examine how individuals and groups experience discrimination in specific environments;
- to learn to identify sources of power and influence in specific environments and intervene to promote psychological well-being; and
- to learn group leadership skills and advocacy.

Domain 6: Psychoeducational groups
Objectives:
- To learn to identify environments and populations that lend themselves to psychoeducational interventions; and
- to learn how to plan, deliver, and assess outcomes of psychoeducational interventions for specific populations and concerns.

Domain 7: Prevention research and evaluation
Objectives:
- To learn needs assessment and program evaluation skills;
- to use quantitative and qualitative research methodologies;
- to develop longitudinal, epidemiological, and experimental research design skills;
- to expand the array of disorders and social units studied across the lifespan;
- to participate in multidisciplinary and collaborative research that addresses systemic and institutional change; and
- to learn effective dissemination practices to inform relevant audiences and policy makers.

Domain 8: Prevention ethics
Objectives:
- To attend to issues of social equity and justice in prevention practices and science;
- to adhere to prevention protocols;
- to increase awareness and knowledge about issues of diversity in the practice and science of prevention; and
- to become familiar with ethical issues and dilemmas in disciplines other than psychology.

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